MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Houston Community Hospital P.O. Box 11586 Houston, Texas 77293	MDR Tracking No.: M4-04-3830-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Chevron/Texaco Corporation/Rep. Box #: 19 C/o Flahive, Ogden & Latson 505 West 12th Street Austin, Texas 78701	Date of Injury: Employer's Name: Chevron/Texaco Corporation Insurance Carrier's No.: 91172909616926

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
7-15-03	7-18-03	Inpatient Hospitalization	$22,324.00	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position statement of December 1, 2003 states "…This disputed claim would fall under TWCC Rule 134.401, Stop Loss Reimbursement Factor, since this claim exceeds $40,000. The carrier paid "per diem" rate of $1,118.00. Houston Community Hospital is requesting this claim be paid per the Stop Loss Reimbursement Factor."

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement of December 10, 2003 states, "… The documentation provided by the Requestor is conflicting in several ways. The table of Disputed Services lists CPT Code 360 billed At $300.00. The UB-92 lists this same code billed at $30,000. The UB-92 lists the dates the statement covers 7/15/03 through 7/18/03, the date of procedure as 7/14/03, and the date of admission as 7/15/03. In addition the operative report lists the date of surgery as 7/14/03. Given the documentation provided, Carrier has paid all fees according to MFG…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." The operative report of July 14, 2003 list the "Preoperative Diagnoses: 1. Recurrent disc herniation L5-S1, right, 2. Herniated disc L4-5, left". Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The Hospital Bill Audit report of September 3, 2003 lists the "U" denial code for Y2700 and Y4200 on July 15, 2003 with denial codes "F" and "N". The reconsideration Hospital Bill Audit report of December 1, 2003 does not list the "U' denial code and in the Respondent's position statement of December 10, 2003 does not address this denial code. Therefore, the "U" denial code is moot and will not be addressed.

The Respondent reimbursed $1,118.00 for 1 day. Accordingly, the standard per diem amount due for this admission is equal to $1,118.00 (1 day times $1,118.00 surgical day). The operative report and anesthesia record shows that the surgery was performed on July 14, 2003, prior to the Hospital admission on July 15, 2003 as listed on the UB-92 and the Table of Disputed Services. Therefore, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Roy Lewis	5-3-05
Authorized Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite # 100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____